REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (I-08)
The Tax Treatment of Health Savings Accounts

EXECUTIVE SUMMARY

At the 2008 Annual Meeting, the House of Delegates adopted as amended the recommendations contained in Council on Medical Service Report 8, "Standardizing AMA Policy on the Tax Treatment of Health Insurance." Recommendation 15 of the amended report calls for our American Medical Association (AMA) to study the tax treatment of health savings account (HSA) contributions, earnings and withdrawals, both currently and upon enactment of legislation to replace the existing employee income tax exclusion for employer-sponsored health insurance with tax credits for individuals and families, as referenced in AMA Policy H-165.852[2] (AMA Policy Database). Specifically, AMA Policy H-165.852[2] states that "contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families."

This report discusses HSAs, AMA policy and advocacy on HSAs, the AMA proposal to expand health insurance coverage and choice, changes in the tax treatment of health insurance that would occur under the AMA reform proposal, and policy alternatives for the tax treatment of HSAs upon enactment of the AMA proposal for reform. Long-standing AMA policy supports HSAs and other forms of consumer driven health care coverage as options in the health insurance marketplace. HSAs and similar forms of coverage involve high-deductible health insurance plans coupled with tax-advantaged savings accounts earmarked for qualified medical expenses. AMA advocacy emphasizes potential advantages unique to such forms of coverage, including reduced premiums, prudent use of health care services, a shift in the locus of health care decision making from third party payers to patients and physicians, and increased savings for future health care needs. The core of the AMA's broader reform proposal to expand health insurance coverage and choice is to redirect the estimated $125 billion federal subsidy for private health insurance by replacing the income tax exemption for employer-sponsored coverage with refundable, advanceable tax credits that are inversely related to income.

AMA policy supports continued tax deductibility of HSA account contributions until such time as the tax treatment of health insurance is restructured as advocated by the AMA reform proposal. At such time, both the health plan and account portions of HSA coverage would become eligible for tax credits structured according to AMA tax credit principles, rather than being tax deductible. The report discusses several policy alternatives to balance the competing objectives of upholding the principle of tax neutrality for all forms of health insurance coverage, restructuring tax subsidies to be inversely related to income, and using the tax code to promote public policy objectives uniquely addressed by HSAs.

The report concludes that, despite the theoretical appeal of such public policy innovations, the drawbacks of adopting novel policy on HSAs outweigh the potential advantages at this time. Introducing significantly new HSA policy poses the risk of detracting from the critical momentum that has finally been gained in advocating tax credits and other elements of the AMA reform proposal. The Council believes that seeking health insurance coverage of the uninsured is a higher legislative priority than changing AMA policy that is currently moot because it would take effect only after major restructuring of the US health insurance system. Accordingly, the Council will continue to explore the tradeoffs and viability of options for the future tax treatment of HSAs under the AMA proposal.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7 - I-08

Subject: The Tax Treatment of Health Savings Accounts

Presented by: David O. Barbe, MD, Chair

At the 2008 Annual Meeting, the House of Delegates adopted as amended recommendations contained in Council on Medical Service Report 8, "Standardizing AMA Policy on the Tax Treatment of Health Insurance." Recommendation 15 of the amended report calls for our American Medical Association (AMA) to study the tax treatment of health savings account (HSA) contributions, earnings and withdrawals, both currently and upon enactment of legislation to replace the existing employee income tax exclusion for employer-sponsored health insurance with tax credits for individuals and families, as referenced in AMA Policy H-165.852[2] (AMA Policy Database). AMA Policy H-165.852[2] states that "contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families."

The Board of Trustees referred the requested study to the Council on Medical Service for a report back to the House at the 2008 Interim Meeting. This report, which is provided for the information of the House, discusses HSAs, AMA policy and advocacy on HSAs, the AMA proposal to expand health insurance coverage and choice, and changes in the tax treatment of health insurance that would occur under the AMA reform proposal. The report concludes with a discussion of policy alternatives for the tax treatment of HSAs upon enactment of the AMA proposal for reform.

OVERVIEW OF HEALTH SAVINGS ACCOUNTS

Since their authorization in 2004 by the Medicare Prescription Drug, Improvement, and Modernization Act, HSAs have received considerable attention from the media, policymakers, and employers as a possible means of increasing patient control over health care decisions, managing rising health care costs, and achieving greater value for health care spending. Like their precursors, medical savings accounts (MSAs), HSAs allow individuals to establish tax-advantaged accounts earmarked for qualified medical expenses, subject to enrollment in a qualified high-deductible health plan. Apart from having higher deductibles, HSA-qualified health plans are like other health plans, with little or no cost sharing for covered, in-network services once the deductible has been met. Account funds may be used to pay for medical expenses before the deductible has been met, and unspent account balances accumulate and accrue interest tax-free from year to year. Compared to MSAs, HSAs are free of many regulatory restrictions, making them more widely available and giving them broader appeal. Initial enrollment in HSAs and similar forms of consumer-driven health care coverage such as Health Reimbursement Arrangements (HRAs) escalated at a rapid rate, although they currently represent only about 5% of health insurance market share.

Both the health plan and savings account components of HSAs are subject to annual dollar limits, which are indexed annually. For 2009, HSA-compatible health plans must have a deductible of at least $1,150 for an individual policy or $2,300 for a family policy. Total deductible, copayment, and coinsurance payments for covered services cannot exceed an annual out-of-pocket limit of

$5,800 for individuals or $11,600 for families. Savings accounts have annual contribution limits of $3,000 for individuals and $5,950 for families, with additional catch-up contributions allowed for those age 55 to 65. Account deposits are deductible from taxable income even for those who do not itemize deductions on their tax returns. Interest earnings and account withdrawals made for qualified medical expenses are also excluded from taxable income. Withdrawals made for other purposes are subject to income tax and, if made before the account holder reaches age 65, an additional 10% penalty.

Table 1 compares different types of tax-advantaged accounts, highlighting the fact that HSAs provide unmatched tax advantages. Deposits to traditional individual retirement accounts (IRAs) are tax deductible whereas withdrawals are subject to income tax. Conversely, Roth IRA deposits are made with after-tax dollars but interest earnings and withdrawals are untaxed. In the case of HSAs, funds are taxed upon neither deposit nor withdrawal, so long as withdrawals are for qualified medical expenses. HSAs can also be used to save for general retirement expenses. As with traditional IRAs, HSA funds used for general expenses are taxed upon withdrawal, with an additional 10% penalty for early, pre-retirement withdrawal. Tax-advantaged individual accounts for medical expenses, including HSAs, HRAs, and flexible spending accounts (FSAs), allow tax-free deposits and withdrawals, but HSAs have the added advantage of being able to accrue interest, tax-free, over a multiyear period.

Table 1. Comparison of Tax-Advantaged Accounts

	Retirement		**Medical**	
	Traditional IRA	**Roth IRA**	**HSA**	**HRA, FSA**
Contributions	UNTAXED	Taxed	UNTAXED	UNTAXED
Interest	Taxed	UNTAXED	UNTAXED	n/a
Withdrawals	Taxed	UNTAXED	UNTAXED	UNTAXED
Penalties (for non-qualified withdrawals)	Taxed +10% penalty if pre-retirement	10% penalty if pre-retirement	Taxed +10% penalty if pre-retirement Taxed if post-retirement	n/a

Like HSAs, contributions to IRAs are subject to annual dollar limits: a maximum of $5,000 for both traditional and Roth IRAs in 2008, with catch-up contributions for those over age 55. Unlike HSAs, however, eligibility and tax deductibility may be restricted on the basis of income. For those with employer-sponsored retirement plans such as a 401(k) or defined-benefit pension plan, contributions to a traditional IRA are tax deductible only if income falls below a specified threshold, and only fully deductible at an even lower income threshold. Similarly, only those below an income eligibility cut-off are eligible to contribute to Roth IRAs. HSAs also provide greater flexibility than traditional IRAs, which require minimum distributions to be made once the account holder has reached age 70½.

Table 2 compares the tax treatment of HSAs and standard health insurance (e.g., PPO and HMO coverage). The top half of Table 2 shows that regardless of whether a health plan is an HSA-qualified high-deductible plan or a standard plan, premium expenditures made by employers (or by the self-employed, and by employees, if made through a Section 125 cafeteria plan) are excluded from employees' taxable income. Employer and employee contributions to HSA accounts are also tax-exempt.

Table 2. Comparison of HSAs and Standard Health Insurance

	HSA	**Standard**
Employer-Sponsored		
Premiums	UNTAXED	UNTAXED
Account	UNTAXED	n/a
Individually Purchased		
Premiums	Taxed	Taxed
Account	UNTAXED	n/a

Since premiums for high-deductible HSA health plans are generally lower than premiums for otherwise-comparable, standard-deductible plans, HSA account contributions offset lower premium costs. Total expenditures on an employee's HSA coverage, inclusive of any account contributions, could be less than or greater than the premium for a standard health plan. Likewise, the amount of employee tax break could be larger or smaller for an HSA compared to standard coverage, even after factoring in the tax break on any future interest earnings. Given that a primary effect of HSAs is to shift the financing of health care services from premium payments to account payments, both components of an HSA can be viewed as a package that merits the same tax treatment as standard employer-sponsored insurance.

As shown in the bottom half of Table 2, premium expenditures for individually purchased insurance, in contrast to premiums for employer-sponsored coverage, are not tax-subsidized regardless of plan type. Contributions to HSA accounts are deductible from the individual or family's taxable income as is the case for employer-sponsored HSAs. In the case of individually purchased coverage, a clear tax preference is given to HSAs over standard health plans because only those with HSAs qualify for any sort of tax break. Those who lack access to employer-sponsored coverage, or who find their employer coverage options unacceptable, receive an income tax deduction on coverage only if they choose an HSA.

Table 3 illustrates the variation in HSA tax break by income. The table shows the reduction in federal income taxes owed as a result of making the maximum HSA account contribution for 2009. The "Single" column represents single tax filers under age 55 who have single coverage under an HSA-qualified high-deductible health plan and make tax-deductible contributions of $3,000 to their HSA accounts. The "Married" column represents couples who file taxes jointly, have family coverage under a high-deductible health plan, and make tax-deductible HSA contributions of $5,950. As shown in the table, for a given HSA contribution, people with higher incomes receive bigger tax breaks than those at lower incomes. Higher income people are in higher tax brackets

and therefore save more on taxes by deducting a given amount. For example, a single person with household income of $25,000 falls in the 15% tax bracket and reduces his or her tax liability by $450 by deducting a $3,000 HSA contribution from taxable income ($3,000 x 15% = $450). By comparison, someone earning $250,000 in the 33% tax bracket saves more than twice as much on taxes as by deducting $3,000 ($3,000 x 33% = $990).

Table 3. Tax Break on Maximum HSA Account Contribution by Income, 2009

Income (HSA Contribution)	**Single** ($3,000)	**Married** ($5,950)
$25,000	$450	$893
$50,000	$750	$893
$75,000	$750	$1,488
$100,000	$840	$1,488
$150,000	$840	$1,666
$250,000	$990	$1,964
$500,000+	$1,050	$2,083

Notes: Income is Adjusted Gross Income (AGI). Tax breaks are illustrative and could vary depending on factors such as number of dependent children and whether the taxpayer pays alternative minimum tax (AMT). Excludes future year tax breaks derived from tax-free interest earnings and withdrawals.

The Joint Committee on Taxation (JCT) reports that 534,000 households deducted HSA account contributions in 2007 (JCT Report No. JCX-66-08, July 2008). Although HSA account holders as a group have higher average income than others, most contribute less to their accounts than the maximum allowed amount. In 2007, the average tax break per HSA account holder was only $626 and the total cost of HSA tax deductions to the federal government was $334 million. By comparison, $334 million is a fraction of the annual cost of excluding employer-sponsored health insurance from employees' federal income tax, estimated at over $125 billion in 2007.

AMA POLICY AND ADVOCACY ON HEALTH SAVINGS ACCOUNTS

The AMA was an early, visible leader in developing the HSA concept and promoting HSAs and similar forms of coverage as options in the health insurance marketplace. AMA lobbying efforts emphasized the following potential advantages of MSAs, HSAs, and HRAs: reduced premiums, increased cost-consciousness, prudent use of health care services, a shift in the locus of health care decision making from third party payers to patients and physicians, increased savings for future health care needs—potentially easing the burden on the Medicare and Social Security programs, and increased patient demand for price and quality information. Over the past decade, the House of Delegates has established a body of AMA policy on MSAs, HSAs, and HRAs, largely through adoption of recommendations in the following Council on Medical Service (CMS) reports:

- "Health Savings Accounts in the Medicaid Program," Council on Medical Service Report 1-A-06;
- "Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans," Council on Medical Service Report 3-I-05;
- "Health Savings Accounts," Council on Medical Service Report 6-A-04;
- "Health Reimbursement Arrangements," Council on Medical Service Report 3-I-03;
- "Establishing Multi-Year Mutual MSA Trust Accounts," Council on Medical Service Report 2-A-03;
- "MSAs and Health Care Coverage of Dependents and Children," Council on Medical Service Report 3-I-02;
- "Critical Expansion of Medical Savings Accounts," Council on Medical Service Report 10-I-99; and
- "Consumer-Driven Health Care," Council on Medical Service Report 12-A-98.

Most of the AMA's legislative objectives for HSAs were achieved with the 2004 authorization of HSAs, including repeal of both the temporary demonstration status of MSAs and the ceiling on the number of MSA accounts that could be established. Another important achievement was relaxation of rules to allow HSA high-deductible plans to offer "first-dollar" coverage of preventive services with little or no cost-sharing even if the deductible has not been met.

AMA Policy on HSAs

Since the authorization of HSAs in 2004, AMA policy and advocacy on HSAs has emphasized education and outreach. Policy H-165.852 calls for HSAs to be incorporated into AMA efforts to expand health insurance coverage and choice. Additional policies support efforts to educate employers, physicians, and the general public about the value of HSAs (Policies H-180.957, H-185.959, D-165.963, and D-165.967), as well as HRAs (Policies H-165.854 and D-165.967). Policy H-165.852[6] calls for the AMA to promote HSAs to physicians through its own health insurance programs, and Policy H-165.852[5] supports the development of innovative products built around HSAs. AMA policy also advocates the use of HSAs toward long-term care and post-retirement medical coverage (Policies H-165.963[7], D-280.990[4], and H-330.898[2]).

AMA policy also seeks certain changes to make HSAs more accessible and easier to implement. Policies D-165.962, H-290.972, and H-290.982 support making appropriately-structured HSAs more widely available as a choice for Medicare and Medicaid beneficiaries. Policy H-165.852[1] seeks more flexible HSA regulations that would allow lower per-person deductibles to apply to individual family members even if the full family deductible has not been met—in keeping with health insurance industry norms. Policy H-165.863 advocates allowing employees to contribute any unspent flexible spending account (FSA) balances into an HSA, and seeks federal legislation rescinding the Internal Revenue Service (IRS) "use-it-or-lose-it" rules requiring annual forfeiture of unspent FSA balances, which would make FSAs resemble HSAs more closely. Several policies promote effective price transparency, including Policies D-180.985, H-373.998, and H-390.875 and Policy H-385.989[2b], which states that physicians should volunteer fee information to patients, discuss fees in advance of service when feasible, accept third party payment as payment in full in cases of financial hardship, and communicate to patients their willingness to make appropriate arrangements in cases of financial need. AMA policy also opposes health plan rules that prohibit physicians from collecting out-of-pocket patient payments at point-of-service, or

offering cash discounts for expedited payment (Policies H-165.849 and D-165.954). Similarly, Policy D-165.954[2] supports research on the impact of HSAs and HRAs on physician practices, as well as the levels and appropriateness of utilization, including preventive care, costs, and account savings.

Several AMA policies refer to the tax-treatment of HSAs (Policies H-165.852[2,7] and H-165.865[1i]). Because these policies address HSAs in the context of the broader AMA proposal for reform, they will be discussed below.

Recent AMA Advocacy of HSAs

Since the establishment of HSAs, the AMA has engaged in numerous related advocacy activities. In 2004, the AMA submitted formal comments to the US Treasury Department on proposed HSA regulations. The AMA brochure *Health Savings Accounts at a Glance*, first published in 2004 to educate the public about HSAs, was used as the prototype for the US Treasury Department publication *HSA Basics*. The updated 2007 edition of the AMA brochure is available at www.ama-assn.org/go/hsaglance. At the 2004 Interim Meeting, the AMA Group and Faculty Practice Caucus sponsored a panel discussion of leading industry and academic experts entitled "HSAs and HRAs: How Are They Impacting Patient Behavior?" The AMA is recognized as an authoritative source of information and guidance on consumer-directed health care. In addition, the AMA Insurance Agency, which had previously offered MSAs to physicians, their families, and their employees, enhanced its product development, marketing, and customer support for HSAs and HRAs.

In 2007, the AMA conducted a Member Connect® survey to understand physicians' knowledge of and experiences with HSAs and HRAs. The survey found that more than half (59%) of physician respondents were knowledgeable about consumer-driven health plans. When asked whether they had patients with HSA or HRA coverage, two-fifths did not know, two-fifths reported having patients who were enrolled in a consumer-driven health plan, and one-fifth reported not having any patients who were enrolled in such plans. Of those physicians with patients enrolled in consumer-driven health care plans, almost two-fifths (38%) reported that the billing and collection for services provided to those patients is more difficult or time consuming, A summary of survey results is available to AMA members at www.ama-assn.org/go/consumer-hcp.

Council on Medical Service Report 3-A-08, "The Role of Cash Payments in All Physician Practices," notes that direct cash payments from patients make up a rising share of physician practice revenues. This trend applies generally, regardless of whether patients have HSA coverage, other coverage or are uninsured, and across physician practices. The AMA's Private Sector Advocacy group and Practice Management Center have developed educational materials and tools to help physicians manage cash transactions in their practices. AMA members and their office staff can obtain these complimentary materials at www.ama-assn.org/go/psa.

THE AMA PROPOSAL TO EXPAND COVERAGE AND CHOICE

The AMA has made covering the uninsured an ongoing, top priority and has developed a proposal to expand health insurance coverage and choice to all patients, regardless of income or health status. For the past decade, the AMA has advocated expanding health insurance coverage and choice by restructuring the tax treatment of health insurance. Council on Medical Service Report 9-A-98, "Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense

Coverage," established the basis of the AMA reform proposal—replacing the existing employee income tax exclusion for employer-sponsored coverage with refundable tax credits that are inversely related to income and applicable toward health insurance of the recipient's choice, whether obtained through an employer or elsewhere. The House of Delegates has subsequently refined the proposal through adoption and filing of approximately 50 additional reports of the Council. The core elements are contained in the following AMA policies:

- H-165.920, "Individual Health Insurance";
- H-165.865, "Principles for Structuring a Health Insurance Tax Credit";
- H-165.856, "Health Insurance Market Regulation"; and
- H-165.848, "Individual Responsibility to Obtain Health Insurance."

The proposal is also grounded in long-standing AMA policy supporting a pluralistic health care system in which patients and physicians have freedom of choice in coverage and delivery of health care, with the growth of any one form of coverage determined by free market competition rather than by preferential government subsidy, regulation or promotion (Policies H-180.995, H-285.998, and H-165.985).

In August 2007, the AMA launched the three-year "Voice for the Uninsured" media campaign to spur action to cover the uninsured. Through the campaign, the AMA reform proposal has been shared with each of the major 2008 Presidential candidates and millions of voters. A series of brief advocacy publications, available at www.VoiceForTheUninsured.org and distributed at the 2007 Interim, 2008 Annual, and 2008 Interim Meetings, describe the three main pillars of the AMA reform proposal: (1) refundable, advanceable tax credits or vouchers inversely related to income to be used for the purchase of health insurance; (2) individual rather than employer choice and ownership of health plans; and (3) fair "rules of the game" that include protections for high-risk patients and greater individual responsibility. The series also discusses related topics such as strategies to address rising health care costs, administrative costs, how the government currently helps people afford health insurance by providing a tax break for job-based coverage, and examples of how replacing the current income tax break with tax credits or vouchers would affect two hypothetical households.

As noted in the advocacy series and numerous Council reports, compensation that employers give employees in the form of health insurance is excluded from the employee's taxable income. This income tax exclusion provides a federal subsidy for job-based coverage of more than $125 billion per year. Because the tax exclusion provides bigger tax breaks to employees in higher tax brackets (i.e., those with higher incomes), the vast majority of the subsidy goes to households earning more than the median annual income of $45,000. The tax exclusion also limits employees' choices to the health plan or plans offered by their employers, and provides nothing to those whose employers do not offer health insurance.

Two general approaches that have been proposed to correct problems with the existing tax treatment of health insurance are discussed in Council Report 5-I-07, "Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions." The first, an income tax deduction for the cost of health insurance, whether employer-sponsored or not, would expand individual choice and level the playing field between employer-sponsored and individually purchased health insurance, but would have little impact on the number of uninsured, since deductions provide bigger tax breaks to those with higher incomes. The second, appropriately structured health insurance tax credits, would expand both individual choice and coverage. Accordingly, AMA

Policy H-180.951 supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage. The AMA reform proposal would redirect the estimated $125 billion annual government subsidy for private coverage toward those most likely to be uninsured, i.e., those with lower incomes, while also expanding individual choice by leveling the playing field between employer-sponsored insurance and individually purchased insurance.

HSAs IN THE CONTEXT OF THE AMA PROPOSAL

In today's health care system, the AMA supports tax deductibility of HSAs as a means of equalizing the tax treatment of HSAs and other forms of health insurance coverage, and as a means of pursuing objectives uniquely promoted by HSAs. These objectives include patient autonomy and responsibility, reduced third party interference in the patient-doctor relationship, demand for and availability of price and quality information, and saving toward future health care needs.

Given that the tax treatment of health insurance would change under the AMA reform proposal, and that current HSA tax deductions provide bigger tax breaks to those with higher incomes, the future tax treatment of HSAs deserves careful consideration. As previously noted, several AMA policies refer to the tax-treatment of HSAs in the context of broader health system reform. Policy H-165.852[7] states that the tax-free use of HSAs should be an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. AMA principles for structuring health insurance tax credits state that tax credits should be applicable only for the purchase of health insurance, including all components of a qualified HSA, and not for out-of-pocket health expenditures (Policy H-165.865[1i]). Policy H-165.852[2] states that contributions to HSAs should be allowed to continue to be tax deductible only until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families.

In accordance with AMA policy, subsidies for HSAs would be the same as for other forms of coverage. That is, subsidies would decrease for those with higher incomes, while becoming more generous for those with lower incomes. Approximately 41% of taxpayers who reported HSA contributions in 2004 had incomes under $60,000 (GAO Report 08-474R, April 2008). Under the AMA reform proposal, this group of HSA account holders would likely receive a tax credit that could be applied to high-deductible plan premiums and/or HSA account contributions. Another likely impact of the tax changes under the AMA proposal is that those who experience a net subsidy loss, that is, those with higher incomes, will tend to migrate toward lower premium, higher deductible health plans, even without the prospect of qualifying for tax-advantaged HSA accounts. HSA coverage will continue to offer attractive features such as lower premiums and greater patient autonomy and financial responsibility in health care decision-making.

POLICY ALTERNATIVES FOR HSAs UNDER THE AMA PROPOSAL

Determining the tax treatment of HSAs under the AMA reform proposal entails policy tradeoffs between three broad objectives: (1) upholding the principle of tax neutrality for different forms of health insurance, thereby allowing market experimentation to find the most attractive combinations of plan benefits and cost-sharing features; (2) providing coverage subsidies that are inversely related to income; and (3) promoting public policy objectives uniquely addressed by HSAs, such as saving toward future health care expenses, prudent use of health care services, and shifting control over health care decision-making from insurers to patients and physicians. The Council considered

major public policy advantages and disadvantages of six scenarios, the first four of which relate to HSA tax treatment and the last two of which relate to HSA eligibility:

- Treat the HSA package like other forms of health insurance: This policy alternative, which regards the health plan and account components of HSA coverage as a package, upholds the principle of tax neutrality and contributes to the overall shift of subsidies toward those with lower incomes. However, this alternative fails to promote objectives uniquely addressed by HSAs after the broader AMA proposal is implemented. AMA policy advocates this alternative (Policies H-165.852[2] and H-165.865[1i]).

- Continue to allow HSA accounts to be tax deductible after implementation of the AMA reform proposal: This policy alternative promotes objectives uniquely addressed by HSAs. However, this alternative violates principles of tax neutrality and structuring tax subsidies to be inversely related to income, especially given that HSAs would become the only form of subsidized coverage for people with incomes too high to qualify for tax credits.

- Remove some but not all HSA tax advantages: This policy alternative strikes a compromise between competing objectives. For example, HSA tax advantages could be modeled after either traditional IRAs or Roth IRAs, so that either contributions or withdrawals are tax-deductible, but not both.

- Augment tax credits with a special HSA tax credit that is independent of income: Princeton economist Uwe Reinhardt has proposed making HSA tax subsidies fairer with respect to income by replacing the HSA tax deduction with a tax credit of 30 cents for every dollar contributed to an HSA account. Compared to the status quo, this policy alternative shifts the HSA tax break toward individuals with lower incomes and promotes objectives uniquely addressed by HSAs, but violates the tax neutrality principle by giving HSA high-deductible coverage preferential treatment over other forms of coverage.

- Allow anyone with heath insurance, regardless of the deductible, to establish an HSA: HSA eligibility could be extended to anyone in compliance with the individual responsibility requirement to have coverage, which initially applies only to those earning more than 500% of the federal poverty level (AMA Policy H-165.848). This policy alternative avoids giving preferential treatment to high-deductible coverage and promotes saving for future medical expenses. However, it violates the principle of structuring tax subsidies to be inversely related to income, and dilutes HSA incentives associated with high-deductible coverage, for example, prudent decision-making and shifting control to patients and physicians. This alternative would also require a careful revisiting of the tax treatment of HRAs and FSAs. In addition, this alternative might provide too large of a subsidy for out-of-pocket expenses with unintended consequences such as increasing health care spending and inflation.

- Combine expanded HSA eligibility with a special HSA tax credit: Allowing anyone with health insurance, regardless of the deductible, to establish an HSA, while also providing an HSA tax credit that is independent of income would achieve the principle of tax neutrality with regard to type of coverage and, to some extent, target subsidies inversely to income and preserve the unique advantages of HSAs.

CONCLUSION

The Council on Medical Service believes that advocating a major change in AMA policy on HSAs at this time is unwarranted. In addition, the Council emphasizes that AMA policy supports continued tax deductibility of HSAs until such time as the tax treatment of health insurance is restructured as advocated in the AMA proposal to expand health insurance coverage and choice. The core of the AMA reform proposal is to redirect the estimated $125 billion federal subsidy for private health insurance by changing it from an income tax exemption for employer-sponsored coverage to refundable, advanceable tax credits inversely related to income. At such time, both the health plan and account portions of HSA coverage would become eligible for tax credits structured according to AMA tax credit principles, rather than being tax deductible.

AMA policy on HSAs in the future upholds the principles of tax neutrality for all forms of health insurance coverage and structuring subsidies to be inversely related to income. AMA policy does not, however, envision using the future tax code to promote public policy objectives uniquely addressed by HSAs. This report discusses several policy alternatives to balance the competing objectives of achieving tax neutrality, targeting subsidies inversely related to income, and promoting objectives uniquely addressed by HSAs. One alternative would be for the federal government to augment income-related health insurance tax credits with special HSA tax credits that are not income-related, also possibly extending HSA eligibility to anyone with health insurance regardless of the deductible level.

Despite the theoretical appeal of such public policy innovations, the Council believes that the drawbacks of adopting novel policy on HSAs outweigh the potential advantages at this time. Foremost, introducing significantly new HSA policy poses the risk of detracting from the critical momentum that has finally been gained in advocating tax credits and other elements of the AMA reform proposal. The Council believes that seeking health insurance coverage of the uninsured is a higher legislative priority than changing AMA policy that is currently moot because it would take effect only after major restructuring of the US health insurance system. Accordingly, the Council will continue to explore the tradeoffs and viability of options for the future tax treatment of HSAs under the AMA proposal.

References for this report are available from the AMA Division of Socioeconomic Policy Development.